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ABSTRACT

In order to design and implement a plan to integrate human sexuality into the curriculum for associate degree nursing students at Alvin Community College (Texas), levels of knowledge, attitudes and skills necessary in promoting sexual health were defined. Of the four levels in the Hims and Swenson Sexual Health Model (life experiences, basic, intermediate and advanced), it was determined that associate degree nursing students needed to attain at least the basic level when functioning with patients. This involves knowledge of anatomy and physiology of the sexual organs, of sexual variations among people, and seeing, hearing, listening and touching skills. Data collected from surveys and questionnaires of nursing students and instructors indicated that there was much misinformation or lack of information among undergraduate and graduate nursing students which could result in behavior detrimental to the patient. The curriculum was reorganized to reflect the desired level of competency through the use of an instructional change model and the development of a series of case studies, which analyze nursing diagnosis, clinical referents and nursing intervention, for six sexual problems. The instructional objectives for the sexuality curriculum and the sexual attitudes questionnaire are included in the document. (TR)

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# DESIGNING A CURRICULUM MODEL TO INCLUDE SEXUALITY AND A PROCEDURE FOR ITS ADMINISTRATION

## HUMAN SEXUALITY - NURSING 50383

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ABSTRACT

The purpose of this study was to design and implement a plan to integrate human sexuality into the curriculum for associate degree nursing students in a community college that would increase the knowledge base for meeting the sexuality needs of clients.

Most schools of nursing have been reluctant to give more than a token support to the inclusion of sexuality in the curriculum. This has created a lack of prepared professionals in the field and thus limited research in sexuality.

In the past, there has been a hesitancy on the part of the client and nurse alike to discuss sexual problems; however, nurses became cognizant of clients sexuality needs and differing sexual response patterns to illness and decided to learn more about the subject in order to help their clients. Also, findings confirmed that there was considerable misinformation regarding sexual matters among both nursing students and nursing instructors. These findings were obtained by a questionnaire which was administered to 121 first year nursing students.

The questionnaire consisted of 100 items which dealt with the subject of sexual attitudes. Results reflected differing attitudes and value systems according to age groups.

The emotional content also challenged the faculty members involved in this study, who found they had to learn to deal effectively with their own sexuality and value systems before they could help students verbalize about sexuality or deal effectively with clients sexual concerns.

By incorporating a sexual health model into an instructional change model, the faculty members at Alvin Community College were able to reorganize the curriculum within and between existing levels to become more process-oriented and less textbook-centered by the addition of improved resources and materials on human sexuality.

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Chapter 1

## Introduction

This study was undertaken in order to determine the methodology necessary to integrate human sexuality into the nursing curriculum in a community college setting. As with other community colleges, Alvin Community College has worked with the assumption that such content belonged only in senior colleges. However, research has shown a dearth of knowledge among the lay public. Nurses of all levels should be able to meet the sexuality needs of clients as well as their other needs and realize that sexuality is on a continuum with other biological, psychological, sociological, and linguistical (BPSL) needs.

## Statement of the Problem

In the past, there has been a hesitancy on the part of the client and the nurse alike to discuss sexual problems. This resulted in part from the value system of the Victorian era which has been perpetrated on succeeding generations. The Kinsey survey in the 1940's followed by Masters and Johnsons' research into sexual behavior in the 1960's did much to change the attitudes of the public as well as to reveal the commonality of problems in the area. For the first time, the public began to discuss sex openly, and their concerns as well as their practices were revealed.

Nurses became cognizant of clients' sexuality needs and differing sexual response patterns to illness and decided to learn more about the subject in order to help their clients. Also, a better informed public was demanding assurance that quality health care include the whole person, not just fragmented parts. With this information as a background, Alvin Community College nursing faculty began the study to determine how and to what extent human sexuality could be integrated into the curriculum.

Background

Curriculums of community colleges as well as those of university programs have to be approved by the Texas State Board of Nurse Examiners. Many subjects fall in the purview of only the universities and are not permissable in a community college. This is not because they could not be covered in a community college setting, but because the time span is short and the number of nursing credit hours have to be limited and must be in a given ratio to academic hours. However, subjects may be integrated into major courses if it is felt that there is a need. Only recently has the need for more knowledge of human sexuality been recognized.

Most schools of nursing have been reluctant to give more than a token support to the inclusion of sexuality in the curriculum. In many schools, sexuality content is provided by various departments other than nursing, a fact which conveys to the nursing student that sexuality is not very important in

health care delivery. If a problem with sexuality does occur in practice, nurses are unprepared and unsure of what to do and question just what a nurse can do to promote sexual health.

But with human sexuality accepted as a part of total health care, nurses have a responsibility to promote sexual health in their practice. In order to assist clients with their sexual concerns, the nurse must have accurate information regarding human sexuality, be accepting of her own sexual values and practices as well as those of others and develop ease in communication skills. This may require new learning on the part of the nurse, and nurse educators must be cognizant of and able to apply the necessary teaching/learning theories if the new knowledge differs from the adult student's value system. Anne Anastasia (1958) stated when new learning runs counter to previous learning, it is reasonable to expect older adults to be handicapped. Previous learning must be unlearned before new learning can be incorporated into the value system. Malcolm Knowles (1960) stated that adults do not respond to the traditional extrinsic rewards of the typical classroom. Many adults require something other than the usual dependency relationship between learner and teacher. The typical knowledge centered curriculum and method has less perceived relevance for the adult than the younger person. In structuring classes for these adult learners, Knowles points out that the orientation talk is important. This

initial presentation describes the behavior objectives (hoped-for outcomes) and a plan for achieving these objectives.

After the nurse has dealt with her own sexuality and value system and reached a resolution, then and only then can she deal effectively with the clients' sexual concerns.

Definition of Terms

As used in this project, the following definitions apply to terms used.

BPSL - biological, psychological, sociological and lingual

Coping mechanism - methods of meeting challenge

Cunnilingus - the act of using the tongue or mouth in erotic play with the external female genitalia (vulva)

Domains:

Affective domain - feeling tone or attitude

Cognitive domain - intellectual or thinking process

Psychomotor domain - motor skills

Desensitization - to make insensitive or nonreactive to a sensitizing agent

Dysparennia - painful intercourse

Explicit sexual materials - sometimes referred to as pornography

Fellatio - the act of taking the penis into the mouth for erotic purposes

Human sexual response:

Excitement phase - the initial phase in the human sexual response cycle that follows effective sexual stimulation

Plateau phase - the fully stimulated stage in the human response cycle that immediately precedes orgasm

Orgasmic phase - the third stage during which orgasm occurs

Resolution phase - last stage in cycle when sexual system retrogresses to its normal non-excited stage

Impotence - disburbance of sexual function in the male that precludes satisfactory coitus; more specifically, inability to achieve or maintain an erection sufficient for purposes of sexual intercourse

Learning - refers to the change in a subjects' behavior to a given situation brought about by his repeated experiences in the situation, provided that the behavior change cannot be explained on the basis of motive response tendencies, maturation, or temporary states of the subject

Mandate - an authoritative command; a formal order

Masturbation - self-stimulation of the genitals through manipulation; autoeroticism

Nursing process - a set of intellectual tasks and cognitive actions and psychomotor skills in a special order which is initiated when the nurse and patient come together and the nurse recognizes the patients' need and takes purposeful interaction toward the resolution of the problem

Orgasmic dysfunction - inability to achieve the plateau phase of the female sexual response cycle

PLISSIT model - a plan for the implementation to effective sexual health care delivery

Premature ejaculation - ejaculation prior to, just at, or immediately after intromission. Ejaculation occurs before the woman can climax in at least 50% of the acts of intercourse

Permission giving - means that the nurse by attitude or word lets the patient know that she sanctions sexual thoughts, fantasies, and behaviors that occur alone or between informed consenting adults

Sensate focus - touching, feeling; preoccupied with things that can be experienced through a sense modality

Sexuality - the condition of having sex; sexual activity

SIECUS - Sex Information and Educational Council of the United States

Transsexualism - a compulsion or obsession to become a member of the opposite sex through surgical changes

Transvesite - a person who receives excitement or gratification, either emotional or sexual, from dressing in the clothes of the opposite sex

Value system - principles or qualities which are held intrinsically valuable or desirable

Limitations

This study was limited in number to the nursing faculty members and to students enrolled in Alvin Community

College during the spring semester, 1978. It was also limited to students from this group who were enrolled in nursing courses during this time.

The study was further limited by the fact that time was not available for long-term evaluation of results. Also, the teachers had to be educated to the new concepts while the study was in progress.

Basic Assumption

The expectations of the study were that the nurse instructors would learn to deal more effectively with clients sexual problems by first becoming more knowledgeable of human sexuality, and second, by teaching their students more about the subject and helping them to apply this knowledge in the clinical setting.

It was also expected that the subjects who were administered the questionnaire would reflect the attitudes and value systems found in much of the general public.

## Chapter 2

## Review of Literature

### The Sexuality Process

Sexuality can be viewed as one of the dynamic life processes with the complexities and the intricate relationships of an individual's developing sexuality, all of which create separate sexual roles within a particular historical time, place and culture. Sexuality, in its broadest sense, might be defined as a deep and pervasive respect of the total personality, the sum total of an individual's feelings and behavior, not only as a sexual being, but as male or female. Throughout the life cycle physiological, emotional, social and cultural forces condition sexuality. The expression of sexuality goes beyond purely genital responses and is constantly modified as a result of sexual responses and social learning. Thus, sexuality is a process that demands and finds expression at all age levels throughout the life cycle.

Because the expression of a person's sexuality is such an integral part of all development, it will follow the overall pattern of health and physical performance. Any alteration in psycho-physiological functioning will have concomitant affects upon the process of human sexuality (Kentzel, 1977).

### Prevalent Patterns of Sexual Behavior in the United States

Recent statistics lend perspective to the variety of sexual behavior the nurse encounters in practice. A recent

study by Hunt (1970) of the sexual attitudes and behavior of 2026 persons in 24 cities and surburban areas, indicated that Americans are engaging in a wider variety of sexual activities more frequently than they did when Dr. Alfred Kinsey (1948, 1953) surveyed American sexual behavior over twenty years ago. This study also showed that an increased number of persons, especially those in younger age groups, are more accepting and tolerant of many forms of sexual behavior. Other changes are present in Hunt's findings.

Nonmarital sexual activity is prevalent and accepted. A comparison of Kinsey's data and Hunt's data shows that the greatest increase in nonmarital sex has occurred in women. Hunt found that approximately 75 percent of single women in the study had had intercourse before the age of 25, although nonmarital sex among males increased only slightly. Among non-college males, about three-quarters of the group had nonmarital coitus by age 17, and of males with some college education, more than half had nonmarital coitus by age 17.

Extramarital sexual activity has also increased more for women than for men. This survey found that 24% of wives and 32% of husbands under age 25 had had extramarital coitus.

Oral sex is practiced more widely than in the past, especially among younger men and women. In approximately 90 percent of married persons less than 25 had practiced cunnilingus or fellatio or both. Oral sex was also engaged in by

over 80 percent of single men and women between 25 and 34.

Heterosexual anal intercourse is more commonly practiced today than in the past. However, it is only an occassional coital variation and engaged in most often by younger persons.

Varieties of coital techniques and frequency of sexual intercourse have increased. The increase in frequency is especially noteworthy in single females between 18 and 24 who are having intercourse and who do so more than once a week (medium frequency). This contrasts sharply with Kinsey's finding that sexually active single women between 16 and 20 had intercourse about once every five to ten weeks.

Even though most individuals are still reluctant to talk about it, today masturbation begins at younger ages in males and females and continues for more years at a higher frequency than at the time of Kinsey's survey in the 1940's. The increase in masturbation is especially apparent in young married men and women. The Hunt survey found that seven out of ten husbands in their late twenties and early thirties masturbated. Although their frequency was lower, almost as many wives in this age group masturbated.

Human Sexual Response Cycle

Health professionals are greatly indebted to Masters and Johnson (1966), pioneers in physiologic aspects of sex. Their work demonstrated that the human sexual response is a cyclic phenomenon consisting of four phases.

The excitement phase develops from any source of sexual stimuli (tactile or psychic) and is characterized by an increment in sexual tension.

The plateau phase is a consolidation period during which sexual tension is intensified immediately before orgasm.

Orgasm, the involuntary climax of sexual tension increment, involves only a few seconds of the sexual response cycle. During this phase, myotonia (muscle tension) and vasocongestion (engorgement of blood vessels) are dissipated.

During the resolution phase, all the changes which occurred during the previous phases are reversed. This involutional phase differs in males and females: women may begin another sexual response cycle immediately, but men must observe a refractory period (if only for a few minutes) during which they cannot regain another erection.

Psychologic Aspects of the Human Sexual Response

Masters and Johnson (1966), Bordwick (1971), and Vincent (1973) have found in their studies valuable information regarding the psychologic aspects of the human sexual response. The descriptions of the subjective exercises of orgasm and ejaculatory inevitability have been solicited by Masters and Johnson. Bordwick contends that women learn to achieve orgasm. Her conclusions support the contention that many sexual problems arise from auto-conditioning; however, just as inhibitions can be learned, they can be unlearned.

Guilt, often a legacy from childhood experience with child-rearing and parental modeling that encouraged a "naughty" view of sex, is learned and can be unlearned. Vincent contends that many people who are dissatisfied with their sexual experiences have problems communicating.

The assembly and interpretation of the data furnished by studies on the subject of sexual response patterns has resulted in the formulation of key concepts which should be considered in planning curricula for health care.

Key Concepts

1. Factors that influence the human sexual response in later life, sextyping, gender identity, and gender role behavior are determined in early prenatal life and early childhood.

2. The human sexual response is a total body response, and is not restricted to the genitalia.

3. Requisites for the human sexual response include an intact circulatory system, to provide for vasocongestive responses, and an intact central and peripheral nervous system, to provide for sensory appreciation and muscular innervation, and to support vasocongestive changes.

4. Other requisites for the human sexual response are an "interested and interesting" partner if the outlet is intercourse.

5. Psychologic variables such as anxiety, guilt, misperception, and learned responses have the potential to interfere with or to interrupt the sexual response cycle.

6. The subjective experience associated with the sexual response varies from individual to individual, and some of this variance-e.g., the difference in perception of satisfaction between masturbation and partner stimulation--cannot be accounted for by science.

Biological, Psychological, Sociological, Lingual (BPSL)

The physical, mental and social components of sexual health care have become an essential part of total health care. Another equally important recent development is that health care is no longer considered synonymous with medical care. Consequently, total health care must include preventive as well as therapeutic aspects of sexuality for all people in all segments of the population.

Human sex covers a broad spectrum and will require a wide range of innovative professional developments and activities to meet the objectives of total health care. Nurses are beginning to get involved, and the nursing literature probably does not reflect accurately the vast activities of nurse practitioners and educators in the development and delivery of sexual health care. It is apparent that nurses need to gain knowledge of human sexuality, improve methods of prevention and treatment of sexual problems, and promote the utilization of their services in the delivery of total health care.

The Current Status of Sex Education in Nursing

In 1973 in an investigation for WHO (World Health Organization) Mace found that little relevant teaching of

human sexuality was being offered in the curriculum of most medical and nursing schools throughout the world. However, this trend rapidly changed, and in the next two years education and counseling opportunities in professional education had grown by leaps and bounds. Surveys of the kind and amount of sex education, which is currently being offered in curricula, are probably obsolete before they reach print.

The nursing profession has been laggard in this area, but its members are beginning to participate in a multi-disciplinary approach toward developing legitimate academic and practitioner skills in sexuality. Many nurses in academic settings have attended some of the better known programs such as those associated with Institute for Sex Research, Inc., Indiana University; American Association of Sex Education and Counselors, Washington D.C.; The Reproductive Biology Research Foundation, St. Louis, Missouri, and others. Consequently, many schools of nursing are beginning to include human sexuality content as an elective, if not a part of their required course work.

The field is still young and the innovative programs are still emerging. A variety of approaches to upgrade knowledge and broaden existing attitudes will be required to meet the needs of the different groups and the individual preparing or practicing in the various health care settings.

There have been many approaches, and probably there is no right or wrong method of obtaining knowledge and

counseling skills in this important area of health care. Most of the learning experiences are not aimed at preparing a skilled sexual therapist, but rather at helping the practitioner integrate sexual health care in relation to mental, social, and physical well being in preventive, therapeutic, and educational aspects of total health care. The nurse must have knowledge of and be comfortable with problem-oriented positions on homosexuality, wanted and unwanted pregnancies, venereal diseases, contraception, sexual functions and dysfunctions, masturbation, gender role, gender identity, sexual offenses, legal implications, and victims of sexual trauma. Clients are asking for accessible services in a myriad of problems related to sexuality. There is also a beginning trend toward women encouraging other women to take more initiative regarding female autonomy in health care. There are certain anxieties about how one becomes knowledgeable and comfortable with their own sexuality, in effective counseling and in becoming nonprejudiced on all issues of sexuality. Many guidelines are available in the literature.

Basic Principles in Promoting Sexual Health

A few principles suggested by Rubin (1970) and quoted by Athanasiou (1973), will help provide a sound foundation for assessment and intervention of sexual problems. These principles are:

1. An acceptance that major value conflicts exist in our society, and that there is no consensus among adults on acceptable values in human sexuality.

2. Guidance should be given by education rather than indoctrination; all known facts and results from research must be dealt with, thus teaching critical judgment in dealing with ethical controversy. This also requires that all health professionals educate themselves and carefully examine their own feelings, values, knowledge, and prejudices.

3. People should be helped toward intelligent self-determination rather than conforming to procedures. Education and counseling must prepare people to make their own choices of conduct which carries with it a responsibility to self and others. We must help to release energies from the many elements of fear, guilt, and ignorance, and help to rechannel these energies toward productive purposes.

Incorporating these three basic principles will be a difficult task for some individuals. Each person has a set of beliefs and prejudices based on his/her own experiences and judgments. These may run counter to one or all three of the basic principles. In addition, there are individuals who have not developed an awareness of their own sexual values, attitudes, and biases. Sexuality has not been dealt with adequately in the past; consequently, many nurses are operating from a very narrow base line. Various aspects of human sexuality have strong emotional connotations, prejudices, stereotypes, and even fears for many health professionals.

In some programs for health personnel, these problems have been met through disensitization, resensitization, and incorporation processes. Desensitization refers to the process

by which an individual, through constant exposure to that which has been a subject of anxiety or stress, becomes accustomed to it, and no longer shows the stress reaction. Resensitization refers to the process by which an individual, through repeated experiences with various aspects of a subject, becomes more aware of its relationship to other areas and is better able to recognize its presence in a given behavioral context. Incorporation is the integrating of a new body of information with previously acquired knowledge in such a way that the new and the old are equally available for use when needed (Vincent, 1968).

A staff or faculty may use the desensitizing and resensitizing process by a flooding of explicit sexual materials, followed by small group discussions.

SIECUS

After incorporating the basic principles and evaluating one's own sexual development, a review of the 1973 Position Statements of SIECUS (Sex Information and Education Council of the United States) should be valuable. After the individual determines what he believes about each of these issues and why, he will probably have less difficulty in assessing and identifying problems, and setting goals regarding various sexual practices. Below are the 1973 SIECUS Position Statements:

1. Sex Education: Free access to full and accurate information on all aspects of sexuality is a basic right for everyone, children as well as adults.

2. Sexual Orientation: It is the right of all persons to enter into relationships with others regardless of their gender, and to engage in such behaviors as are satisfying and nonexpolitative. Discrimination based on sexual orientation is a violation of this right.

3. Masturbation: Sexual self-pleasuring, or masturbation, is a natural part of sexual behavior for individuals of all ages. It can help to develop a sense of the body as belonging to the self, and an affirmative attitude toward the body as a legitimate source of enjoyment. It can also help in the release of tension in a way harmless to the self and to others, and provide an intense experience of the self as preparation for experiencing another. Masturbation, and the fantasies that frequently accompany it, can be important aids in maintaining and restoring the image of one's self as a fully functioning human being.

4. Contraception Care for Minors: Contraceptive services should be available to all--including minors who should enjoy the same rights of free and independent access to medical contraceptive care as do others.

5. Explicit Sexual Material: The use of explicit materials (sometimes referred to as pornography) can serve a variety of important needs in the lives of countless individuals and should be available to adults who wish to have them. In this regard we find ourselves in entire agreement with t'e Majority Report of the President's Commission on Obscenity and Pornography.

6. Sex and Aging: Aging people are too often deprived of opportunities for sexual companionship and expression, which they need despite unscientific beliefs to the contrary. Society has an obligation to create conditions conducive to the fulfillment of these needs.

7. Sex and Racism: In any efforts aimed at identifying and improving a society's attitudes and understanding about racism, distortions of facts which are sexual in nature must be recognized and combated as such. Racism is frequently manifested by distorted views of the sexuality of ethnic groups, creating barriers to interpersonal relationships.

8. Sex and the Handicapped: The sexual nature and needs of individuals with physical and mental handicapping conditions have rarely been considered in the past. Today the need for total human relationships is increasingly recognized. Parents, professionals, and society in general have the obligation to make it possible for the handicapped to live responsible, rewarding, and fulfilling sexual lives in accordance with their capacities.

9. Sex--The Law and the Citizen: In agreement with the Model Penal Code of the American Law Institute, sexual behavior engaged in by consenting adults should not be the concern of the law.

10. Sexual Health Care: Sexual health care is a valid concern of the total health care to which everyone is entitled, and therefore provisions must be made for it in health care planning, with relation to mental and social as well as physical well-being.

The nurse should have the knowledge and awareness to be able to determine if the client should be referred for sexual counseling. Below are a few suggestions for assessment and intervention in counseling clients desiring assistance in the improvement of sexual health.

Assessment and Intervention Methodology

I. Assessment of the Problem:

A. Determine if the client appears to present a potential danger to himself or others, or if the behavior is a sexual choice made with a coequal obligation of responsibility.

B. Find the actual precipitating event or symptom that has caused alarm for the client or others.

C. Determine if there is a threat to a significant relationship or social role that has emerged or is emerging due to sexual behavior or attitudes.

D. Determine the psychosocial needs that confront the person as a consequence of sexual attitudes or behavior.

E. Determine the customary range of problem-solving resources or ego-coping mechanisms that is employed to deal with sexuality.

F. Determine if there are new factors or conditions involved in the psychosexual development that have mitigated the usefulness of habitual behavior or ways of coping.

II. Communicating to the Client the Essence of the Problem:

Use a direct approach describing to the client the relationship of feelings, conflict, or symptoms, and the elements leading to the need for understanding and/or change.

III. Intervention:

This will depend upon the identification of the problem or problems in the assessment process and the existing goals or the new goals set by the client and/or counselor. Some of the areas in which the client may need help are:

A. Gaining an intellectual understanding and examining his own feelings regarding a specific experience, condition, or relationship.

B. Understanding that a personal sexual choice is a fundamental right.

C. Acquiring accurate information and clearing up sexual myths and misconceptions.

D. Bringing into awareness the present feelings about his own and others' sexuality. Often guilt, anger, denial, or sexual feelings are suppressed. Catharsis may be healthy.

E. Exploring possible alternative ways of sexual expression.

F. Formulating the relationship of sexual health with mental, social, and physical well-being.

IV. Evaluation and Anticipatory Planning:

A. Determining and reconfirming the progress made toward the goals by the counselee and counselor.

B. Summarizing positive changes in behavioral terms.

C. Determining the specific reinforcing factors that resulted in adaptive behavior.

D. Discussing the learning and attitude change that has taken place in the present experience that may be helpful with other psychosexual developmental tasks.

E. Planning of referral for treatment if the need and motivation are present.

The nurse must also take advantage of educational opportunities to gain knowledge of psychosexual growth and development during the entire life span.

Sexual health programs need to be affiliated with a reputable health agency with professional supervision. All programs and new approaches must be evaluated to determine their effect on sexual health care.

## Chapter 3

## Methods and Procedures

A procedure utilized to gather data to determine the needs of students in the nursing program regarding knowledge of human sexuality was the administration of a questionnaire. This questionnaire consisted of 100 items which dealt with the subject of sexual attitudes (Appendix 1). It was administered to 121 first year students during an appropriate time in Maternity Nursing. The data was tabulated and the results were shared with students as a class activity. The findings served as a basis for discussion regarding the differences and basis of attitudes of human sexuality.

### Population

Of the 121 questionnaires distributed, all were sufficiently completed to use in the study. The population was predominantly female with 106 females and 15 males and also predominantly white with 86 white, 29 blacks and 5 listed as other. In the group there were 16% under 20 years of age, 37% in the 20's, 35% in the 30's and 8% over 40 years of age. For a description of marital status for the population, 27% were single, 59% were married and 12% were designated as separated, divorced or widowed. Of those that were married, 71% had been married over three years and 57% had been married only once. There were 8% of the population who had an income less than $5,000 per year, 23% from $5,000 to $10,000,

39% from $10,000 to $15,000 and 22% who were in a income bracket from $15,000 to $25,000 and 4% in an income bracket over $25,000 per year. A description of religious preference designated 49% as Protestant, 30% as Roman Catholic, 7% as Atheist or Agnostic and 24% as other.

Activities Regarding Sexual Behavior

In response to the question regarding opinion about premarital sexual intercourse, attitudes varied:

10% - It is all right for both young people and adults.

23% - It is all right for consenting adults.

4% - It is all right for couples who share affection.

16% - It is all right for couples who are in love.

4% - It is all right for couples who are engaged.

36% - It is wrong; couples should wait until they are married.

In response to the question toward homosexuality, 52% expressed that they did not care to engage in homosexual relations but thought it a matter of individual choice; 42% expressed that it was a character disorder, a kind of mental illness or a perversion. Only 3% felt that there was nothing wrong with it; there is an element of homosexuality in everyone.

In response to the item regarding the accessibility of contraceptive techniques and devices, 66% of the group expressed that anyone should have access; 14% expressed that only married couples or couples about to be married; 16% thought that only grown people should have access with 2% designating over 21 and 14% designating the age of over 21;

5% felt that no one should have access to contraceptives. Of the group, 81% agreed that effective contraception can increase sexual enjoyment and 43% agreed that easy access to birth control information and devices increases promiscuity.

The tabulation of responses to the questions regarding the most liberal conditions for legal abortion which should be allowed showed varying opinions as follows:

31% - Upon demand by a woman.

8% - When mother is in danger, unmarried or unable to care for the child.

11% - When the child might be deformed or retarded.

8% - When pregnancy is the result of rape or incest.

29% - When the mother's life is in danger.

8% - Not under any circumstances.

Sexuality Education

In response to the question asking the source of their sex information when they were children, the following responses were given: 62% from friends; 16% from parents; 12% from sex education books, 4% from a course in school. 52% stated that sex was never a subject of family conversation; 35% stated that sex was seldom a conversation topic and 10% stated that sex was discussed occasionally. When asked to rate their own sexual attitudes as compared to those of the average person, the following ratings were given:

13% - Very liberal

27% - Somewhat liberal

33% - Moderate

16% - Somewhat conservative

9% - Very conservative

Sexual Health Model

In order to meet the objectives of this project, using the conceptual model as a guide, it became necessary to define the various levels of knowledge, attitudes and skills necessary in promoting sexual health. The adaptation of the PLISSIT Model used by Mims and Swenson proved to be an invaluable tool. (Figure 1)

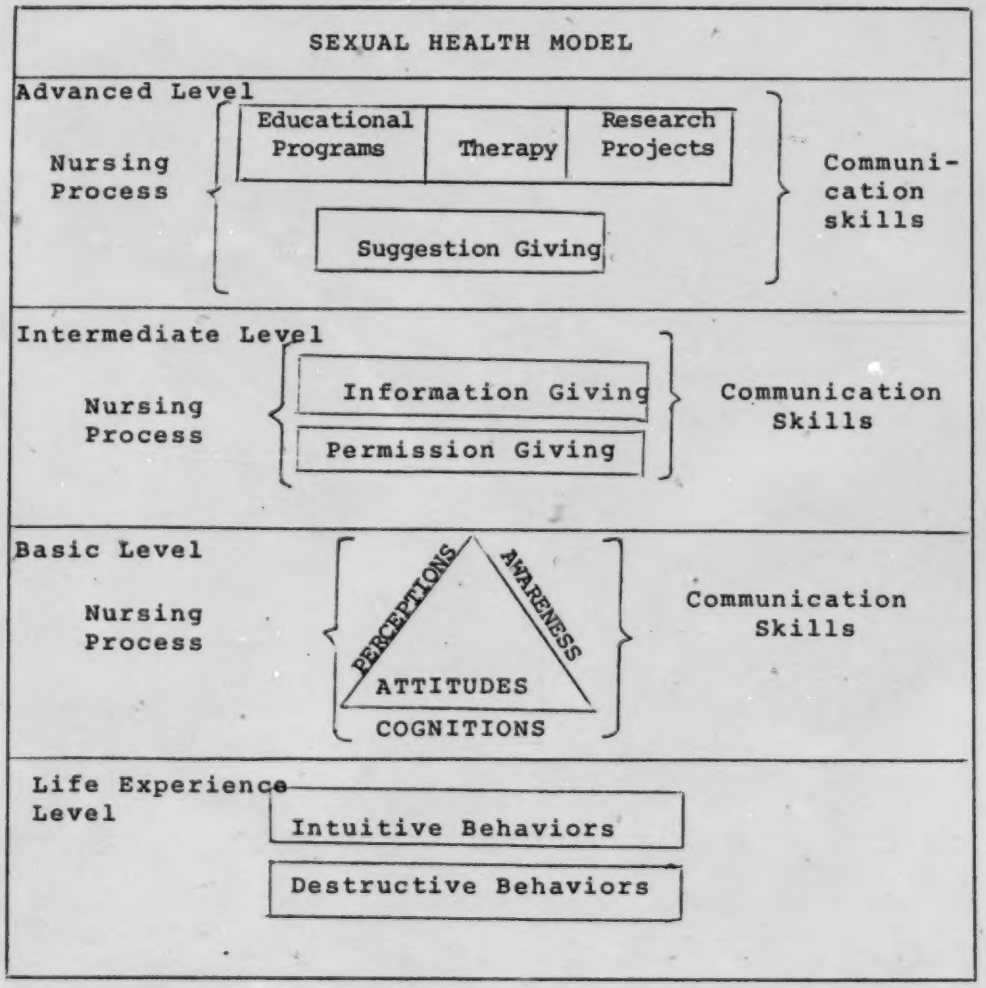



Figure 1. Mims and Swenson's Sexual Health Model

The four levels in the Health Model included: Life Experiences Level, Basic Level, Intermediate Level, and Advanced Level.

Life Experiences Level

The first or lowest level consisted of the Life Experiences Level and included both destructive and intuitively helpful behaviors that a person develops from living in a society that places so much emphasis on sex. Many destructive behaviors are based on myths, stereotypes, taboos, and fears that are culturally determined.

A study showing many areas of misinformation, was conducted at a university and included 109 seniors and graduate nursing students. It was shown that these areas of misinformation were potentially destructive to assisting clients with their sexual health needs. Among the data obtained, the following beliefs were evidenced:

- Thirty-five percent of the subjects believed that impotence in men over seventy is nearly universal.
- Ten percent believed that certain conditions of mental and emotional instability are demonstrably caused by masturbation.
- Twenty-four percent believed that for a period of time following orgasm, women are not able to respond to further stimulation.
- Twenty-seven percent believed that most homosexuals have a body build with distinguishing features.

- Sixteen percent believed that a woman's chances of conceiving are greatly enhanced if she has had an orgasm.
- Thirty-two percent believed that exhibitionists are latent homosexuals.
- Eighty percent believed that transvestism is usually linked to homosexual behavior.

These findings confirmed that there is considerable misinformation or lack of information regarding sexual matters among nursing students, both graduate and undergraduate.

It is recognized that the ability to provide sexual health care is highly correlated with sexual knowledge and positive results. Considering the findings of the study, this lack could result in destructive behaviors, such as not discussing sexuality with a patient recuperating from a surgical procedure that could interfere with his sexual life. This is also included in the Sexual Health Model on the lower level called Life Experiences. Negative life experiences also affect nurses attitudes toward sexuality. Some nurses will remember from childhood many verbal and nonverbal messages implying that sex is "dirty." Not all of life experiences contain negative connotations about sexuality, and some are positive behaviors. In the Sexual Health Model, positive behaviors are labeled as intuitive interactions and are dependent upon the quantity and quality of life experienced by the nurse. This is not to say that one should operate exclusively from life experiences as

this may prove to be a haphazard method of delivering sexual health care.

Basic Level

The basic level is the second level and begins to employ the nursing process. This includes one's cognitions, attitudes, and perceptions of sexuality. Some of the cognitive areas include knowledge of anatomy and physiology of the sexual organs as well as sexual variations among people. Perceptions are dependent on seeing, hearing, listening, and touching skills. All nurses, regardless of formal educational preparation, must reach at least this level of functioning with clients. Since Alvin nursing students are community college students, it was found that this basic level was the level at which most of them could function.

Intermediate Level

Additional educational opportunities are provided at the intermediate level. It is here where the learner acquires clinical skills in applying the nursing process. The intermediate level also includes communication skills, as does all levels, but at this level, communication skills facilitate permission and information giving. Permission giving means that the nurse by attitude or word lets the patient know that she sanctions sexual thoughts, fantasies, and behaviors that occur alone or between informed consenting adults. Permission giving alleviates many sexual concerns for the client. By her actions and attitudes, the nurse conveys to the client permission to engage or not engage in specific sexual behaviors. If coital

activity is not discussed, the cardiac patient and partner may falsely believe that they should not resume sexual activity. Fear, ignorance, and misinformation have prevented many clients from enjoying sexual intercourse. In some situations, the nurse may have an opportunity to become a stronger influence than the super-ego by promoting permission for sexual curiosity, to engage in oral-genital sex, self-pleasuring exercises, or homosexual activities. At the same time, the nurse needs to give herself permission to her own biases, as long as these biases are not imposed on clients.

A word of caution needs to be made to nurses concerning the detrimental effects of permission giving without providing accurate information. Clients need to know that certain antihypertensive drugs can decrease libido or interfer with ejaculation (Kaplan, 1974). Some hormonal treatment for cancer increases sexual urges for women (Kennedy, 1976). Many tranquilizers and antidepressants effect ejaculation, decrease the ability to maintain erection, and reduce sexual desire (Woods, 1975). Information may be given to the diabetic man that there may be a sexual urge despite the absence of potency. According to Masters and Johnson (1970), this information may prevent the intense frustration and distrust that is experienced between the diabetic and his partner when information is lacking.

To be successful in using the nursing process at the intermediate level, the nurse needs a course in human sexuality, followed by supervised clinical practice. Since sex education has not been a universal practice, many families can benefit

from accurate and current information in many aspects of sexuality.

Advanced Level

The advanced level of the Sexual Health Model includes suggestion giving, educational programs, therapy, and research projects. Sensate focus is an example of a specific suggestion a nurse might give. This prescribes a comprehensive communication process to achieve sexual responsiveness. The sensate process begins by encouraging tenderness, affection, understanding, and warmth of pleasurable touching. The receiver and the giver discover what experiences are most pleasurable for each of them.

Sexual therapy may involve cotherapy, sex counseling clinics, group counseling, marital counseling, or family counseling. If a nurse is to function on the advanced level, she must be aware of the most common sexual problems: orgasmic dysfunction and dyspareunia in a woman and impotence and premature ejaculation in a man.

Not many nursing schools or graduate programs have included human sexuality as a required course. This has limited research in sexuality because of the lack of prepared professionals in this field. In developing a curriculum to include sexuality at Alvin Community College, the emotional content challenged the nurse educators to use a creative format to meet the divergent needs of each group. The main objectives of sexuality programs usually focus on an increase of knowledge and an awareness of feelings, biases, prejudices, and attitudes of self and others; therefore, these concepts and objectives were

used at Alvin Community College in planning this project.

Instructional Change Model

The catalyst for this plan was a need oriented Instructional Change Model (Figure 2) and was aimed at including human sexuality in the nursing program. The levels of knowledge, attitudes, and skills set forth in the Sexual Health Model were incorporated into this change model. The change model proposed by Bishop (1976) was used as the basic design and was explicated in a fully developed plan with graphic representations of delineated needs peculiar to Alvin Community College.

Bishop set forth the major areas of this plan as follows: needs, diagnosis, analysis, objectives, development, validation, implementation and evaluation. Each area has been described in this study as it pertained to the program under study.

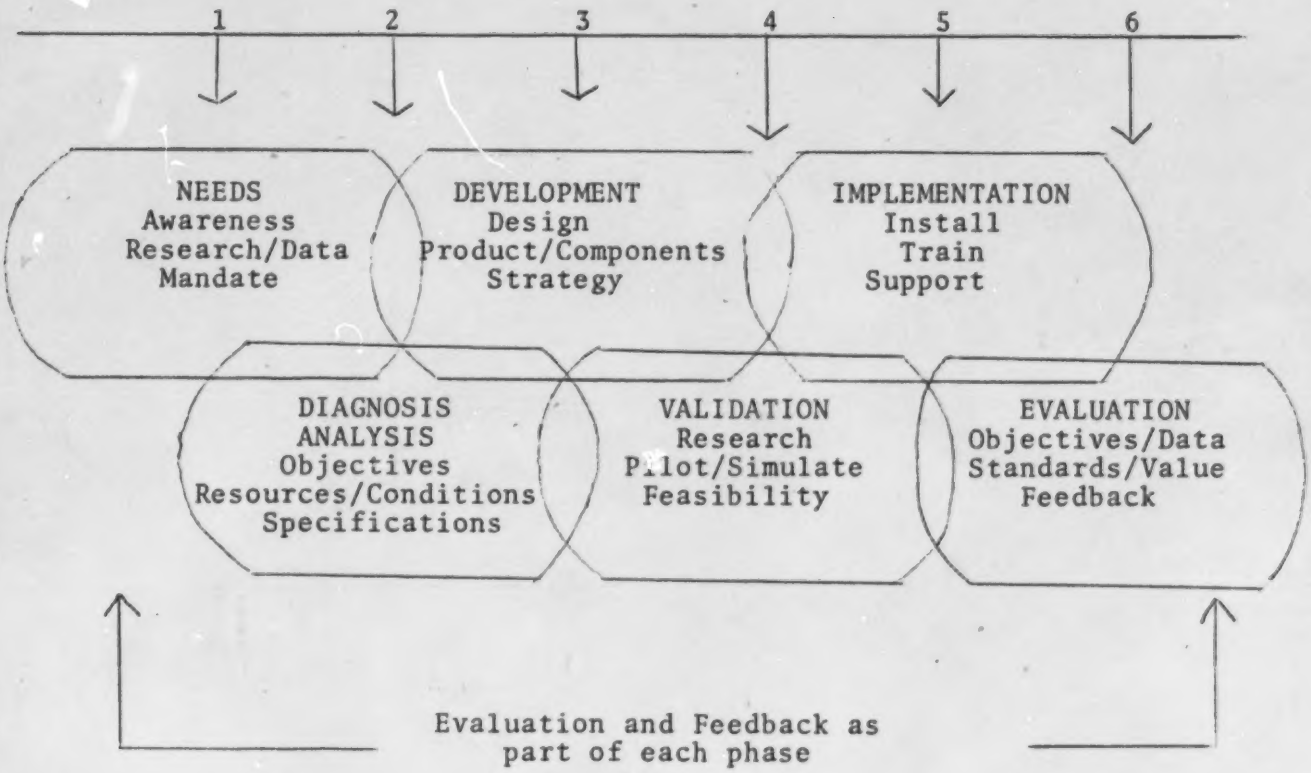
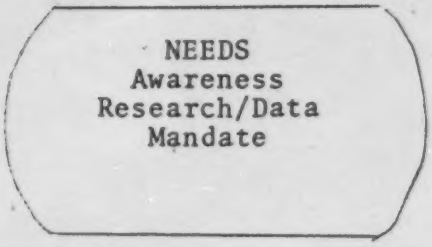



Figure 2. "Instructional Change Model" (Bishop, 1976, p. 4).



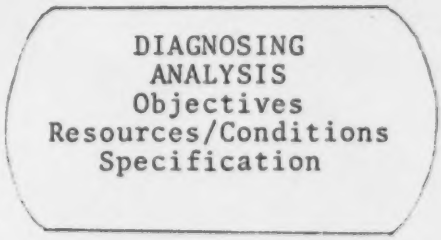

Needs arise from a variety of sources. Awareness is the necessary ingredient in creating change. It indicates those needs that are sensed and more or less agreed upon. However, no supporting data of any consequence of the awareness of sexual health has existed until recently. Where the need is mandated, i.e., made imperative by powers such as the Board of Nurse Examiners, then the program must fulfill this mandate. However, schools are given some choice in determining its needs. The second basic level of the Sexual Health Model (Figure 1) begins to employ the nursing process and is based on awareness. In the model, awareness is composed of all of one's cognitions, attitudes, and perceptions of sexuality. Some of the cognitive areas include: 1) knowledge of anatomy and physiology of the sexual organs; 2) psycho-sexual development; 3) psychosocial behaviors; and 4) sexual variations among people.

Attitudes also include the feelings, values, and beliefs of the individual concerning sexuality. In order to develop a greater understanding and tolerance of sexuality in self as well as in others, it is necessary to know what one's attitudes are.

Awareness must begin at the basic level if the nurse is to acknowledge, identify, and promote sexual health. This

awareness in nurses can be promoted by attendance at sexual workshops or in formal courses in human sexuality. Such courses increase the nurse's knowledge of sexuality while also identifying their attitudes and improving their use of perceptive communication (Woods, 1975).

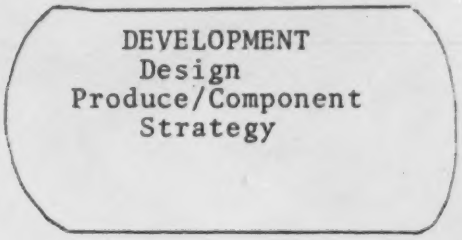
Also, awareness is fluid and constantly changing. This indicates a need for continuous study. The learning and changes that take place at the basic level often create anxiety and frustration in the learner unless additional educational opportunities can be provided. This can be achieved at the intermediate level by providing the learner the opportunity to acquire clinical skills in applying the nursing process.




During the diagnosing phase, the nursing students should be allowed input so that the teacher may analyze their expertise and individual differences in sexual understanding. This should include identification of goals and objectives. The resources available to them, and the conditions under which these exists will determine to a great extent the learning that will occur.

Specification will be delayed until the learner reaches the intermediate level. For example, this may involve sexual counseling for handicapped clients who need to express their

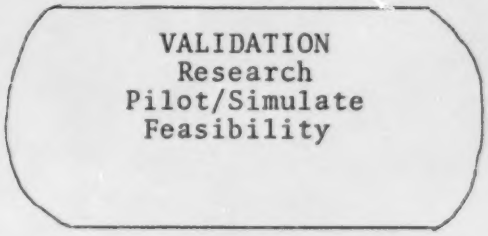
sexual needs even though they cannot master coitus. Until the learner can deal effectively with her/his own feelings in such matters, she/he cannot deal with such specifications.




The development of a program that will include human sexuality will by necessity, include all the components of an educational system and will need a model such as the conceptual model. It must also include input from other faculty members and from those in administration who will be intimately involved in the program.

Most schools of nursing have been slow to include sexuality in the curriculum. In many schools sexuality content is provided by various departments other than nursing, and very few experiences in clinical practice are provided which deal specifically with a condition relating to problems of altered sexual response. Ommission of providing sexual education must be remedied if the nurse is to function adequately in dealing with this integral portion of health care delivery. At the present time, if a problem with sexuality does occur in practice, nurses are unprepared and unsure of what to do and question their ability to provide sexual information. Strategy to offset such ill-preparedness was used in this project and

was based on the PLISSIT Model developed by Annon (1976) for the behavioral treatment of sexual problems. This model was adapted to nursing education.



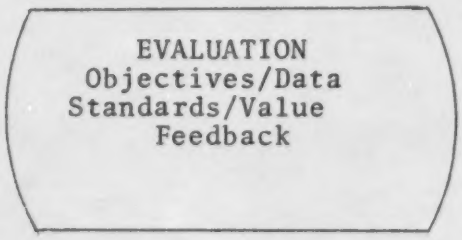

Validation through a procedure such as pilot testing is possible in some instances, but pilot testing takes time and results can only be researched after a program has been instituted for some time. Therefore, simulation was used in this study and critical assessment of appropriateness and adequacy of the process was of value in identifying the problems and determining the soundness of the proposed solutions.

The questionnaire that was administered to students in the nursing program seemed to be the only feasible way to gain input in the short time span, and it did provide valuable insight into the thinking and knowledge of our students.

Implementation demanded full commitment by the total nursing faculty directly involved in including sexual content

in the curriculum. It was also necessary to obtain the support of college administration and instructional staff members that were teaching the academic support courses that interfaced the nursing courses. This included the professors of psychology and anatomy and physiology. Students were apprised of the rationale and encouraged to participate fully in the endeavor.

For the faculty's part, it became necessary for each one to assess her own level of competency in promoting sexual health and in providing a framework for defining attainable learning goals after this assessment. Most of the faculty were in graduate school and were taking or had taken courses in human sexuality. Therefore, awareness of the deficit in this area in our curriculum for associate degree nursing students was evidenced along with the realization of the necessity for inclusion of sexual education in future curriculums. From this frame of reference, the educational program in sexuality was developed.




Formative and summative evaluation procedures were used. Formative evaluations during the implementation process was used to improve the program while it was still under

development, and summative evaluations will be made at the end after graduates of the program are in practice.

The objectives of sexuality programs that were set forth earlier in this paper were used to plan the content, and more specific enabling objectives resulted from the feedback.

## Chapter 4

## Results and Findings

Comparison of content areas offered in the existing nursing curriculum with that accepted by the faculty as necessary for a knowledge base for the professional nurse, revealed deficit areas of content for human sexuality education. A plan was designed to improve the educational program by including the necessary content in this subject area.

### Theoretical Base for Classroom Focus

The knowledge base needed to provide an effective and thorough understanding of sexuality in order to plan and implement nursing care was identified (McCary, 1973). Objectives for content to be presented were arranged sequentially in order to have ease of placement into the progressive order of the five nursing courses in the curriculum. These were:

### Human Sexuality Objectives

1. Define the concept of human sexuality.
2. Recognize the importance for the health professional to assess self and acquire sexual knowledge.
3. Relate this to the holistic approach to man in health and illness.
4. Identify prevalent patterns of sexual behavior in the United States.

5. Discuss the human sexual response cycle.
6. Identify resources for developing skills and knowledge and assessing attitudes toward sex and sexuality.
7. Begin to evaluate one's own beliefs, values and attitudes toward sexuality and one's level of sexual knowledge.

Reproductive System Objectives

1. Locate on a model or patient the following structures of the female reproductive system and related structures:
   a. mons veneris
   b. prepuce
   c. clitorus
   d. labia majora
   e. labia minora
   f. urinary meatus
   g. vaginal orifice
   h. perineum
   i. anus
   j. symphysis pubis
   k. sacrum
   l. coccyx
2. Demonstrate a breast exam noting:
   a. symmetry
   b. areolae
   c. nipples
   d. Montgomery's tubercles
   e. consistency of breast tissue
   f. secretions

3. On a patient or gynecological model, perform a manual vaginal exam identifying:
   a. vaginal wall
   b. ischial spine
   c. cervix
4. Locate on model or patient the following structures of the male reproductive system:
   a. penis
   b. scrotum
   c. testes
5. Describe the four phases of the human sexual response:
   a. excitement phase
   b. plateau phase
   c. orgasm
   d. resolution phase

Minor Disequilibrium of the Reproductive System Objectives

1. Identify in relation to the venereal diseases:
   a. etiology
   b. signs and symptoms
   c. transmission
   d. diagnosis and treatment
   e. client education
   f. nursing care measures
   g. effects of BPSL status of client

2. Identify in relation to benign prostatic hypertrophy:
   a. signs and symptoms
   b. treatment
   c. appropriate nursing intervention
3. Describe the menstrual cycle.
4. Describe the climacteric and menopause.
5. Discuss abnormal uterine bleeding in relation to:
   a. etiology
   b. classification
6. Identify in relation to benign gynecologic conditions:
   a. etiology
   b. signs and symptoms
   c. transmission
   d. diagnosis and treatment
   e. client education
   f. nursing care measures
   g. effects on BPSL status of client
7. Describe inflammatory and infectious problems in relation to:
   a. etiology
   b. signs and symptoms
   c. transmission
   d. diagnosis and treatment
   e. client education
   f. nursing care measures
   g. effects on BPSL status of client
8. Identify nursing measures appropriate to clients undergoing a D&C or hysterectomy.

9. Identify components of the gynecologic history.
10. Identify the components of the pelvic exam.
11. Discuss the use of the Papanicolaou Smear as a diagnostic test; define the classes used in reporting findings.
12. Discuss infertility in relation to:
    a. common causes
    b. evaluation
13. Describe the methods of birth control in relation to:
    a. effectiveness
    b. client teaching
14. Define abortion including classification of types.
15. Describe the pharmacodynamics of drugs used in the management of alterations of the reproductive system.

Sexual Dysfunction Objectives

1. Identify in relation to orgasmic dysfunction:
    a. primary
    b. secondary
    c. etiology
    d. therapy
2. Identify in relation to premature ejaculation:
    a. etiology
    b. therapy
3. Identify in relation to impotence:
    a. etiology
    b. therapy

## Early Childhood Influences on Behavior Objectives

1. Analyze briefly some effects of various child rearing techniques in relation to:
   a. healthy behaviors
   b. neurotic behaviors
   c. psychosomatic behaviors
   d. sociopathic behaviors
   e. psychotic behaviors

## Personality Development Objectives

1. Normal personality development throughout the life span.
2. Variables that effect personality development.
   a. heredity
   b. environment
   c. self-determination
3. Environmental factors that inflict stress upon an individual, family or group.
   a. physical
   b. psychological
   c. socioeconomic
   d. political
4. Define the following terms:
   a. socialization
   b. asocial
   c. antisocial
   d. seclusiveness
   e. masochism

f. rigidity

g. compulsive

h. dyssocial

i. sexual deviants

j. egocentric

k. low frustration tolerance

l. transvestism

m. exhibitionism

n. pedophilia

o. fetishism

p. homosexuality

5. Identify characteristics of the client manifesting symptoms of sociopathic behaviors, i.e.,

a. rape

b. sexual behavior variances

1. homosexuality

2. pedophilia

3. exhibitionism

4. prostitution

5. sadism

6. masochism

Sexuality of the Elderly Patient Objectives

1. Define the following terms:

a. sexuality

b. ageism

c. stereotype

2. Begin to understand and reject sexual stereotypes directed at the aging.
3. Identify examples of sexual stereotypes.
4. Identify three factors influencing sexual activities in the elderly.
5. Recognize the sexual needs of those over 65.
6. Recognize both the sexual limitations and potentialities of the age group over 65.
7. Identify the psychological and physiological changes in the male and female which affect sexual intercourse in this time period.
8. Direct older clients with sexual problems to sources of assistance.
9. Identify nursing measures appropriate to sexual matters with elderly clients.

Nursing Implications

Six nursing problems for the client with altered sexual responses were defined in the literature (Campbell, 1978). For each of these nursing diagnosis, clinical referents and nursing interventions were identified. These problems served as the guide for curriculum planning for the provision of clinical experiences in the area of sexuality health care.

I. Nursing Diagnosis

Difficult adaptation to role reversal: a period of difficult emotional adjustment in which the person attempts to adapt to the loss of some of the social

components that make up the total personality structure of being a whole man or woman.

Clinical Referents:

Subjective data

Humiliation

Fears rejection

Decreased self-esteem

Considerable anxiety

Objective data

Woman financially supports the family, although her husband had done so previously.

Man assumes household chores, which his wife previously did.

Can no longer assume previous responsibilities, which remain unattended to or are divided or assigned to others.

Nursing Intervention

Approach unhurriedly.

Provide an atmosphere.

Express empathy.

Express warmth and friendliness.

Arrange situations which encourage patient autonomy.

Assist patient in restructuring his lifestyle.

Emphasize the person's value as an individual.

Encourage acceptance of interdependency.

Encourage acceptance of self limitations.

Encourage the expression of feeling.

Listen attentively and talk with the patient.

Offer feedback of the patient's expressed feelings.

Encourage the sharing of common problems with others.

Encourage strivings toward realistic goals.

Recognize the need for the use of appropriate defense mechanisms.

Encourage the use of normal coping mechanisms.

Recognize the need for unique personal adjustments to change.

Explore with the patient his strengths and resources.

Explore with the patient reasons for self-criticism.

Support a realistic assessment of the situation.

Introduce to persons who have successfully undergone the same experience.

Provide objects which symbolize sex identity.

II. Nursing Diagnosis

Reduced female sexual response: diminshed ability of the female to respond to sexual activity.

Clinical Referents

Subjective data

Decreased sexual desire and responsiveness.

Perceives sexual activities as undesirable.

Objective data

Blames reduced response on a natural or surgical menopause or hormonal deficiency.

Complains of changed attitudes in the partner.

Previous aggressive personality becomes passive.

Nursing Intervention

Approach unhurriedly.

Provide an atmosphere of acceptance.

Express empathy.

Reassure verbally.

Encourage awareness of positive responses from others (the partner).

Encourage the expression of feelings.

Listen attentively and talk with the patient.

Offer feedback of the patient's expressed feelings.

Recognize the need for the use of appropriate defense mechanisms.

Encourage the use of normal coping mechanisms.

Explore superficial topics and reasons for voiding in-depth feelings.

Explore with the patient his strengths and resources.

Explore with the patient reasons for recurring problems.

Explore with the patient the effects of his behavior on others (the partner).

Provide emotional support for persons significant to the patient.

Refrain from negatively criticizing.

Support a realistic assessment of the situation.

III. Nursing Diagnosis

Reduced male sexual response: inability of the male to perform the sex act satisfactorily.

Clinical Referents

Subjective Data

Diminished sexual satisfaction

Grief

Anxiety

Depression

Worries about mate's reaction

Male perceives himself as less of a man

Objective Data

Partially or totally unable to perform sexual activities.

Focuses more on preintercourse sexual activity.

Nursing Interventions

Approach unhurriedly.

Provide an atmosphere of acceptance.

Express empathy.

Reassure verbally.

Encourage awareness of positive responses from others (the partner).

Encourage the expression of feelings.

Listen attentively and talk with the patient.

Offer feedback of the patient's expressed feelings.

Recognize the need for the use of appropriate defense mechanisms.

Encourage the use of normal coping mechanisms.

Explore superficial topics and reasons for avoiding in-depth feelings.

Explore with the patient his strengths and resources.

Explore with the patient reasons for recurring problems.

Explore with the patient the effects of his behavior on others (the partner).

Provide emotional support for persons significant to the patient.

Refrain from negatively criticizing.

Support a realistic assessment of the situation.

IV. Nursing Diagnosis

Rejection related to sex misidentification: feeling of being rebuffed by others because one assumes social characteristics usually reserved for the opposite sex.

Clinical Referents

Subjective Data

Cannot accept himself as a man or herself as a woman.

Desires to be a person of the opposite sex.

Person feels that he is not acceptable to others.

Feels that he does not receive the care and attention he deserves because of his variance from social standards of the majority.

Objective Data

Female:

Displays generally accepted male behavior and dress.

Prefers to work in male-identified occupations.

Is competitive.

Is aggressive.

Has coarse body movements.

Male:

Displays generally accepted female behavior and dress.

Is preoccupied with domestic affairs.

Prefers female-identified occupations and working with women rather than men.

Prefers sentimental and romantic movies and literature.

Has feminine body movements.

Nursing Interventions

Approach unhurriedly.

Provide an atmosphere of acceptance.

Reassure verbally.

Provide frequent patient contact.

Avoid causing painful emotional situations.

Emphasize the person's value as an individual.

Encourage awareness of positive responses from others.

Encourage the expression of feelings.

Listen attentively and talk with the patient.

Offer feedback of the patient's expressed feelings.

Explore superficial topics and reasons for avoiding in-depth feelings.

Explore with the patient his strengths and resources.

Explore with the patient reasons for criticism by others.

Explore with the patient reasons for criticism of others.

Explore with the patient reasons for recurring problems.

Recognize the need for the use of appropriate defense mechanisms.

Encourage the use of normal coping mechanisms.

Refrain from negatively criticizing.

V. Nursing Diagnosis

Rejection related to variant sexual preferences: feelings of being rebuffed by others because of one's preference for having sexual relationships with members of the same sex, rather than with members of the opposite sex.

Clinical Referents

Subjective Data

Person feels that he is not acceptable to others.

Feels that he does not receive the care and attention he deserves because of his variance from social standards of the majority.

Fantasizes that his spouse is of the same sex.

Derives strong emotional satisfaction from members of the same sex.

Objective Data

Sometimes there is a partnership in which one member assumes an active male role and the other a passive female role, although both are of the same sex.

Married to a member of the opposite sex, but would rather be married to a member of the same sex.

Nursing Interventions

Approach unhurriedly.

Provide an atmosphere of acceptance.

Reassure verbally.

Provide frequent patient contact.

Avoid causing painful emotional situations.

Emphasize the person's value as an individual.

Encourage awareness of positive responses from others.

Encourage the expression of feelings.

Listen attentively and talk with the patient.

Offer feedback of the patient's expressed feelings.

Explore superficial topics and reasons for avoiding in-depth feelings.

Explore with the patient his strengths and resources.

Explore with the patient reasons for criticism by others.

Explore with the patient reasons for recurring problems.

Recognize the need for the use of appropriate defense mechanisms.

Encourage the use of normal coping mechanisms.

Refrain from negatively criticizing.

VI. Nursing Diagnosis

Self-dissatisfaction related to sex misidentification: unhappiness with oneself for having assumed social characteristics usually reserved for the opposite sex.

Clinical Referents

Subjective Data

Cannot accept himself as a man or herself as a woman.

Desires to be a person of the opposite sex.

Dislikes himself for wanting to be of the opposite sex.

Feels he is not an acceptable person.

Desires to change his behavior.

Objective Data

Female:

Displays generally accepted male behavior and dress.

Prefers to work in male-identified occupations.

Is competitive.

Is aggressive.

Has coarse body movements.

Male:

Displays generally accepted female behavior and dress.

Is preoccupied with domestic affairs.

Prefers female-identified occupations and working with women rather than men.

Prefers sentimental and romantic movies and literature.

Has feminine body movements.

Nursing Intervention

Approach unhurriedly.

Provide an atmosphere of acceptance.

Reassure verbally.

Emphasize the person's value as an individual.

Encourage the expression of feelings.

Listen attentively and talk with the patient.

Offer feedback of the patient's expressed feelings.

Explore with the patient reasons for self-criticism.

Explore with the patient his strengths and resources.

Assist the patient in defining consistent life standards.

Encourage the practical application of the accepted value system.

Assist the patient in defining consistent life standards.

Encourage the practical application of the accepted value system.

Assist the patient in restructuring his lifestyle.

Introduce to persons who have successfully undergone the same experience.

Provide objects which symbolize sex identity.

Recognize the need for the use of appropriate defense mechanisms.

Encourage the use of normal coping mechanisms.

Refrain from negatively criticizing.

## Chapter 5

### Summary and Conclusions

The purpose of this study was to design and implement a plan to integrate human sexuality into the curriculum for associate degree nursing students at Alvin Community College, Alvin, Texas, that would increase the knowledge base for meeting the sexuality needs of clients.

The problem was that in the past, there had been a hesitancy on the part of the client and the nurse alike to discuss sexual problems. Also, findings confirmed that there was considerable misinformation regarding sexual matters among nursing students, both graduates and undergraduates.

In developing a curriculum to include sexuality at Alvin Community College, the emotional content challenged the nursing instructors to use a creative format to meet the divergent needs of both the faculty and the students. Negative life experiences were found to affect some of the nursing instructors' attitudes. Some nurses remembered from childhood many verbal and nonverbal messages implying that sex was "dirty". However, all the nursing faculty had been or were in graduate school and all had had some formal education in human sexuality.

The nursing profession is beginning to participate in a multidisciplinary approach toward developing academic and practitioner skills in sexuality. Many nurses in academic

settings have attended some of the better known programs on sexuality, and consequently, many schools of nursing are beginning to include sexuality content in their courses.

After the nursing instructors had dealt with their own sexuality and value systems and had reached a resolution, they were then able to deal effectively with the clients' sexual concerns and to help students to verbalize about sexuality.

Using the Sexual Health Model developed by Mims and Swenson, Alvin Community College instructors were able to incorporate this model into an Instructional Change Model. The sexual model consisted of four levels in the following ascending order: life experiences level, basic level, intermediate level and advance level. Since Alvin nursing studens are community college students, it was found that the second level, the basic level, was the one on which most of them could function.

This basic level begins to employ the nursing process and includes one's cognitions, attitudes, and perception of sexuality. Some of the cognitive areas include knowledge of anatomy and physiology of the sexual organs as well as sexual variations among people.

The curriculum was reorganized within and between existing levels, and it was more process oriented and less textbook centered by the addition of improved resources and materials on human sexuality.

Formative evaluations were made while the program was still in progress and positive feedback could be given, and

summative evaluations will be made at the end of the program after the students graduate and go into practice.

Expectations were that after implementation of the educational plan, nursing instructors would learn to deal more effectively with clients' sexual problems and would be able to teach their students more about the subject and to help them apply this knowledge in the clinical setting. Feedback from the instructors does not refute this expectation.

Implications

The implications for the community college under study can hardly be overestimated. Because the expression of a person's sexuality is such an integral part of all development, it will follow the overall pattern of health and physical performance. Any alteration in psycho-physiological functioning will have comcomitant effects upon the process of human sexuality.

It is apparent that nurses need to gain knowledge of human sexuality, improve methods of prevention and treatment of sexual problems, and promote the utilization of their services in the delivery of health care.

Recommendations

The nursing instructor can make a definite contribution to the enlightment of and knowledge of human sexuality and ways of meeting the needs of clients as a total response.

To do this, however, she must determine the extent of knowledge of human sexuality in her particular community or

college; determine what resources are available to her and to the client and avail herself of them; increase her knowledge and understanding of the subject by reading and attending educational programs, lectures, and discussions when the opportunity presents itself. She must also let her students know she is available and willing to discuss any problems they have with answering sexual questions posed by their clients. The nursing instructor should also be instrumental in encouraging colleges to allow open and frank discussion of all aspects of sex and family living. Information to students should be accessible so that they would not be hesitant to seek such knowledge. Finally, instructors should encourage students to design and participate in projects and fairs regarding sexual health.

BIBLIOGRAPHY

Anastasia, Anne. Differential Psychology. New York: MacMillan Company, 1958.

Annon, Jack. "The PLISSIT Model," Journal of Sex Education Therapy, 2:1-5. Spring-summer, 1976.

Bardwick, Judith. The Psychology of Women: A Study of Basic Cultural Conflicts. New York: Hayes & Row, 1971.

Bishop, Leslie, Jr. Staff Development and Instructional Improvements: Plans and Procedures. Boston: Allyn and Bacon, Inc., 1976.

Browning, May and Lewis, Edith (Ed.). Human Sexuality: Nursing Implications. New York: The American Journal of Nursing Company, 1973.

Campbell, Clare. Nursing Diagnosis and Intervention. New York: John Wiley & Sons, 1978.

Hunt, Morton. "Sexual Behaviors in the 1970's," Playboy, 20: 85-88, October 1973.

Kaplan, H.S. The New Sex Therapy. New York.

Kennedy, B. J. "Effects of Massive Doses of Sex Hormones on Libido," Medical Aspects of Human Sexuality, 11: 67-68, March, 1976.

Kintzel, Kay. Advanced Concepts in Clinical Nursing. New York: J. B. Lippincott, 1977.

Kinsey, Alfred C. et. al. Sexual Behavior in the Human Male. Philadelphia, W. B. Saunders, 1948.

Kinsey, Alfred C. et. al. Sexual Behavior in the Human Female. Philadelphia: W. B. Saunders.

Knowles, Malcolm S. (Ed.). Handbook of Adult Education in the United States. Chicago: Adult Association of the U.S.A., 1960.

Masters, W. H. and Johnson, Virginia. Human Sexual Response. Boston: Little Brown and Company, 1966.

McCary, Jones. Human Sexuality. New York: D. Van Nostrand Company, 1973.

Mims, Fern and Swenson, Melinda. "A Model to Promote Sexual Health Care." Nursing Outlook. February, 1978.

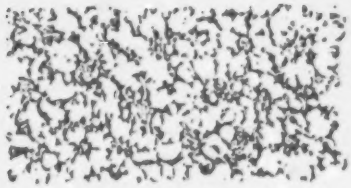
Vincent, Clark. Sexual and Marital Health: The Physician as Consultant. New York: McGraw-Hill Book Company, 1973.

Woods, Nancy and Anne Mandetta. "Human Sexual Response Patterns." The Nursing Clinics of North America. London: W. B. Saunders Company, 1975.

"World Health Organizations Ask: Are Health Professionals Competent to Deal With Human Sexuality?" News SIECUS Report. 1:4, July, 1973.

# APPENDIX

# Questionnaire: Sexual Attitudes



1. How closely do you think love and sex are linked?

   ☐ 1. Sex and love are independent and sex should be enjoyed for its own sake.

   ☐ 2. Love greatly enriches sexual relations, but is not necessary for enjoyment.

   ☐ 3. Sexual intercourse without love is not enjoyable.

   ☐ 4. Sexual intercourse is sacred and should be reserved for the expression of serious love.

2. In choosing a sex partner, which would you prefer?

   ☐ 1. Someone sexually naïve.

   ☐ 2. Someone with at least a little sexual experience.

   ☐ 3. Someone sexually sophisticated.

3. What is your opinion about premarital sexual intercourse?

   ☐ 1. It is all right for both young people and adults.

   ☐ 2. It is all right for consenting adults.

   ☐ 3. It is all right for couples who share affection.

   ☐ 4. It is all right for couples who are in love.

   ☐ 5. It is all right for couples who are engaged.

   ☐ 6. It is wrong; couples should wait until they are married.

4. If you have engaged in premarital sexual intercourse, how do you feel about it now?

   ☐ 1. Very regretful.

   ☐ 2. Somewhat regretful.

   ☐ 3. No feelings.

   ☐ 4. Somewhat glad.

   ☐ 5. Very glad.

   ☐ 6. Not applicable.

5. In your experience, what influences your choice of a sex partner? (Rank the following in order of importance by numbering from 1 to 4.)

   ☐ A. Physical attractiveness.
   ☐ B. Intelligence.
   ☐ C. Attitudes similar to yours.
   ☐ D. Warmth and affection for you.

6. Usually, what effect does taking alcohol have on you in sexual intercourse?

   ☐ 1. It greatly enhances enjoyment.

   ☐ 2. It somewhat enhances enjoyment.

   ☐ 3. It has no effect.

   ☐ 4. It somewhat decreases enjoyment.

   ☐ 5. It greatly decreases enjoyment.

   ☐ 6. Not applicable.

7. Usually, what effect does taking marijuana have on you in sexual intercourse?

   ☐ 1. It greatly enhances enjoyment.

   ☐ 2. It somewhat enhances enjoyment.

   ☐ 3. It has no effect.

   ☐ 4. It somewhat decreases enjoyment.

   ☐ 5. It greatly decreases enjoyment.

   ☐ 6. Not applicable.

8. What is your attitude toward homosexuality?

   ☐ 1. Prefer homosexual relations to the exclusion of heterosexual relations.

   ☐ 2. In many ways, homosexuality is preferable

   ☐ 3. There is nothing wrong with it; there is an element of homosexuality in everyone

   ☐ 4. I do not care to engage in homosexual relations, but I think it is a matter of individual choice.

☐ 5. It is a character disorder, a kind of mental illness, and homosexuals need therapy.

☐ 6. It is a perversion and should be suppressed.

9. What effect do you think recent Supreme Court decisions about censorship and pornography have had?

☐ 1. Have seriously threatened moral standards.

☐ 2. Have established reasonable guidelines.

☐ 3. Have been too restrictive.

10. How do you personally feel about extramarital sexual intercourse. (Extramarital is used to denote sexual activity with someone other than one's spouse.)

☐ 1. It adds dimension to marriage, and there is nothing wrong with it.

☐ 2. It is permissible if you and your spouse agree.

☐ 3. It is all right for either partner as long as he/she doesn't talk about it.

☐ 4. It is all right, but the consequences can be disastrous.

☐ 5. It is all right for men, but not for women.

☐ 6. It is allowable under very special or extreme circumstances.

☐ 7. It is wrong whatever the reason.

11. What is your attitude toward the idea of group marriages—unions in which several couples share conjugal rights?

☐ 1. Strongly in favor.

☐ 2. Mildly in favor.

☐ 3. No opinion, but might be interested.

☐ 4. Neither for it nor against it.

☐ 5. Mildly disapprove.

☐ 6. Strongly disapprove.

12. Who should have access to contraceptive techniques and devices?

☐ 1. Anyone.

☐ 2. Anyone over twenty-one.

☐ 3. Anyone over eighteen.

☐ 4. Only married couples or couples about to be married.

☐ 5. No one.

13. In your opinion what should be the most liberal condition for legal abortion?

☐ 1. Upon demand by a woman.

☐ 2. When the mother is underage, unmarried or unable to care for the child.

☐ 3. When the child might be deformed or retarded.

☐ 4. When the pregnancy is the result of rape or incest.

☐ 5. When the mother's life is endangered.

☐ 6. Not under any circumstances.

14. Who should have access to explicit manuals of sexual intercourse?

☐ 1. Anyone.

☐ 2. Anyone over twenty-one.

☐ 3. Anyone over eighteen.

☐ 4. Only couples who are married or are about to be.

☐ 5. No one.

15. What was the attitude toward nudity in your home when you were a child?

☐ 1. Very casual, much nudity.

☐ 2. Casual, some nudity.

☐ 3. Neither concern nor unconcern.

☐ 4. Concern that people were properly attired.

☐ 5. Much concern, no nudity.

16. What do you think is the best source of sex instruction for children?

☐ 1. Books.

☐ 2. Friends.

☐ 3. School.

☐ 4. Parents.

☐ 5. Church.

☐ 6. Other (please specify).

---

**17.** What is an appropriate standard of sexual behavior?

☐ 1. Men and women should be free to decide for themselves about premarital and extramarital sexual intercourse.

☐ 2. Men and women should be free to engage in premarital intercourse, but not extramarital.

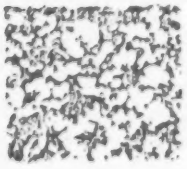
☐ 3. Women should not agree to extramarital intercourse, but it is reasonable to expect that men will.

☐ 4. Premarital relations are permissible for either sex.

☐ 5. Women should not engage in either premarital or extramarital intercourse, but men may.

☐ 6. Men, but not women, may engage in premarital intercourse, but neither should have extramarital intercourse.

☐ 7. Neither men nor women should have sexual relations outside of marriage.



**How strongly do you agree or disagree with each statement in this section?**

1. Strongly agree.
2. Moderately agree.
3. Slightly agree.
4. Slightly disagree.
5. Moderately disagree.
6. Strongly disagree.

**18.** Being in love gives life meaning and direction.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**19.** Premarital sexual relations often equip persons for more stable and happier marriages.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**20.** Sex education in elementary and high schools is likely to encourage premarital sexual activities.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**21.** Most of us can sincerely love any one of several people equally well.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**22.** A person who waits for ideal love is a fool.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**23.** Effective contraception can increase sexual enjoyment.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**24.** Lovers ought to expect a certain amount of disillusionment after they marry.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**25.** Prostitutes should be subject to fines and imprisonment.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**26.** Toplessness is indecent and should be outlawed.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**27.** The law has no business regulating sexual relations between consenting adults.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

**28.** Most of the time women would prefer a sex partner who is gentle and affectionate rather than forceful and aggressive.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

29. Birth control should be a matter of individual conscience.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

30. Women should feel free to initiate sexual activity.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

31. Even if a girl has had sexual experience, she should pretend to be sexually naive at the time of marriage.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

32. Often, couples who have sex together and then marry wish that they had waited.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

33. Sexual behavior should be judged by the quality of the relationship between people and not by whether they are married.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

34. Easy access to birth-control information and devices increases promiscuity.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

35. In general, women do not enjoy sex as much as men.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

36. Sharing interests with your sex partner is as important as love.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

37. Love is more important than practical considerations.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

38. Religious groups should not attempt to impose their standards of sexual behavior on others.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

39. Homosexuals should be considered as no better than criminals.

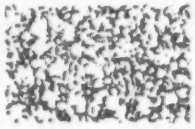
1☐ 2☐ 3☐ 4☐ 5☐ 6☐

40. When you are in love, you see qualities in your beloved that other people do not appreciate.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐

41. True love seldom lasts forever.

1☐ 2☐ 3☐ 4☐ 5☐ 6☐



42. What is your sex?

☐ 1. Male.

☐ 2. Female.

43. What is your age?

☐ 0. Under twenty.

☐ 1. From twenty to twenty-four.

☐ 2. From twenty-five to twenty-nine.

☐ 3. From thirty to thirty-four.

☐ 4. From thirty-five to thirty-nine.

☐ 5. From forty to forty-four.

☐ 6. From forty-five to forty-nine.

☐ 7. From fifty to fifty-four.

☐ 8. Fifty-five or over.

44. To which racial group do you belong?

☐ 1. White.

☐ 2. Negro.

☐ 3. Oriental.

☐ 4. Other (please specify).

_____

**45.** What is your marital status?

- ☐ 1. Single.
- ☐ 2. Married.
- ☐ 3. Separated.
- ☐ 4. Divorced.
- ☐ 5. Widow.
- ☐ 6. Widower.

**46.** If you are single, are you

- ☐ 1. Going steady.
- ☐ 2. Engaged.
- ☐ 3. Not applicable.

**47.** How many years have you been married (include all marriages)?

- ☐ 0. None.
- ☐ 1. Three months or less.
- ☐ 2. Four to six months.
- ☐ 3. Six months to one year.
- ☐ 4. One to two years.
- ☐ 5. Three to five years.
- ☐ 6. Six to eight years.
- ☐ 7. Nine to eleven years.
- ☐ 8. Twelve or more years.

**48.** How many times have you been married?

- ☐ 1. Once.
- ☐ 2. Twice.
- ☐ 3. Three times.
- ☐ 4. Four times.
- ☐ 5. Five times or more.

**49.** If you are unmarried, are you cohabiting?

- ☐ 1. Yes—with a person of the opposite sex.
- ☐ 2. Yes—with a person of the same sex.
- ☐ 3. No.
- ☐ 4. Married.

**50.** If you have children, what are their sexes?

- ☐ 1. No children.
- ☐ 2. All boys.
- ☐ 3. At least one boy and one girl.
- ☐ 4. All girls.

**51.** What was the circumstance of your first child's birth?

- ☐ 1. Born out of wedlock.
- ☐ 2. Born after marriage but conceived before marriage.
- ☐ 3. Born after seven to nine months of marriage.
- ☐ 4. Born after less than two years of marriage.
- ☐ 5. Born between second and third years of marriage.
- ☐ 6. Born between third and fifth years of marriage.
- ☐ 7. Born after fifth year of marriage.

**52.** What effect did children have on your marriage?

- ☐ 1. Positive.
- ☐ 2. Negative.
- ☐ 3. Both positive and negative.
- ☐ 4. No effect.
- ☐ 5. Don't know.
- ☐ 6. No children, not married.
- ☐ 7. No children, married.

**53.** Do you think your children will someday have premarital sex relations?

- ☐ 1. Highly probable that they will not.
- ☐ 2. Moderately probable that they will not.
- ☐ 3. Can't say.

☐ 4. Moderately probable that they will.

☐ 5. Highly probable that they will.

**54.** What is your present religious preference?

☐ 1. Atheist, agnostic.

☐ 2. Unitarian.

☐ 3. Jewish.

☐ 4. Protestant.

☐ 5. Roman Catholic.

☐ 6. Other.

**55.** What kind of religious instruction did you receive when you were a child?

☐ 1. Atheist, agnostic.

☐ 2. Unitarian.

☐ 3. Jewish.

☐ 4. Protestant.

☐ 5. Roman Catholic.

☐ 6. Other.

**56.** How religious would you say you are?

☐ 1. Very religious.

☐ 2. Somewhat religious.

☐ 3. Slightly religious.

☐ 4. Not at all religious.

☐ 5. Antireligious.

**57.** What is the population of the city or community you live in?

☐ 1. Less than 10,000.

☐ 2. From 10,000 to 50,000.

☐ 3. From 50,000 to 100,000.

☐ 4. From 100,000 to 500,000.

☐ 5. From 500,000 to 1,000,000.

☐ 6. Over 1,000,000.

**58.** What area of the country would you call your home?

☐ 1. West.

☐ 2. Southwest and mountain states.

☐ 3. Midwest.

☐ 4. South.

☐ 5. New England and Middle Atlantic states.

**59.** What state do you live in now?

**60.** What level of education have you completed?

☐ 1. Grade school.

☐ 2. High-school graduate.

☐ 3. Some college.

☐ 4. College graduate.

☐ 5. Some graduate work.

☐ 6. Master's degree.

☐ 7. Ph.D., M.D., or other advanced degree.

**61.** What is the approximate annual income of your family?

☐ 1. Less than $5,000.

☐ 2. From $5,000 to $10,000.

☐ 3. From $10,000 to $15,000.

☐ 4. From $15,000 to $25,000.

☐ 5. More than $25,000.

**62.** What is your political affiliation?

☐ 1. Republican.

☐ 2. Independent.

☐ 3. Democrat.

☐ 4. Other.

**63.** How would you describe your political views?

☐ 1. Very liberal.

☐ 2. Somewhat liberal.

☐ 3. Moderate.

☐ 4. Somewhat conservative.

☐ 5. Very conservative.

**64.** What is your occupation? (Please give a full description.)

_____

_____

_____

**65.** Do you work professionally as one of the following?

☐ 1. Doctor.

☐ 2. Psychologist or psychiatrist.

☐ 3. Social worker or counselor.

☐ 4. Engineer or scientist.

☐ 5. Public administrator.

☐ 6. Law-enforcement officer.

☐ 7. Clergyman.

**66.** Overall, how do you rate your marriage?

☐ 1. Very happy.

☐ 2. Happier than average.

☐ 3. Average.

☐ 4. Somewhat unhappy.

☐ 5. Very unhappy.

☐ 6. Unmarried.

**67.** Most marriages, even happy ones, have some problems with sexual relations. How important have sexual problems been in your marriage?

☐ 1. Very important.

☐ 2. Somewhat important.

☐ 3. No significant sex problems.

☐ 4. Not important at all.

☐ 5. Unmarried.

**68.** Do you think that a woman can pursue a full-time career and be a good wife and mother?

☐ 1. Yes.

☐ 2. Maybe.

☐ 3. No.

**69.** How old were you at the time of your first heterosexual intercourse?

☐ 1. Fourteen or younger.

☐ 2. Fifteen to seventeen.

☐ 3. Eighteen to twenty.

☐ 4. Twenty-one to twenty-three.

☐ 5. Twenty-four to twenty-eight.

☐ 6. Twenty-nine to thirty-three.

☐ 7. Thirty-four to thirty-eight.

☐ 8. Thirty-nine or older.

☐ 9. None.

**70.** With whom was your first intercourse?

☐ 1. Spouse, after marriage.

☐ 2. Fiancé.

☐ 3. Steady date.

☐ 4. Someone you had known for a while but not dated steadily.

☐ 5. Casual acquaintance.

☐ 6. Stranger.

☐ 7. Prostitute.

☐ 8. Relative.

☐ 9. None.

**71.** After the first time, how many times did you have sexual intercourse with that person again?

☐ 1. Not again.

☐ 2. Once or twice.

☐ 3. Three or four times.

☐ 4. Five to ten times.

☐ 5. Ten or more times.

☐ 6. More than ten times and still having intercourse.

☐ 7. Not applicable.

72. With how many persons have you had premarital sexual intercourse?

☐ 0. None.

☐ 1. One.

☐ 2. Two.

☐ 3. Three.

☐ 4. Four.

☐ 5. Five.

☐ 6. Six.

☐ 7. Seven or more.

73. With how many different persons have you had extramarital sexual intercourse?

☐ 0. None.

☐ 1. One.

☐ 2. Two.

☐ 3. Three.

☐ 4. Four.

☐ 5. Five.

☐ 6. Six.

☐ 7. Seven or more.

☐ 8. Never married.

74. How long was it after your marriage that you first had extramarital sexual intercourse?

☐ 0. Never.

☐ 1. Less than one year.

☐ 2. One to two years.

☐ 3. Three to five years.

☐ 4. Six to eight years.

☐ 5. Nine to eleven years.

☐ 6. Twelve to fifteen years.

☐ 7. Sixteen or more years.

☐ 8. Never married.

75. How often have you engaged in extramarital sexual intercourse during the past year?

☐ 0. Not at all.

☐ 1. Once.

☐ 2. Twice.

☐ 3. Three times.

☐ 4. Four to ten times.

☐ 5. Monthly.

☐ 6. Weekly.

☐ 7. Daily.

☐ 8. Never married.

76. Have you participated in wife swapping?

☐ 1. Frequently.

☐ 2. Once or twice.

☐ 3. Not ever, but I might.

☐ 4. Never; would never consider it.

☐ 5. Never married.

77. Have you had sexual intercourse with more than one person at a time?

☐ 1. Yes, frequently.

☐ 2. Yes, once or twice.

☐ 3. No, but I might consider it.

☐ 4. No, and I would never consider it.

78. In the past six months how often, on the average, did you engage in sexual intercourse?

☐ 1. Not at all.

☐ 2. A few times.

☐ 3. Once or twice a month.

☐ 4. Once or twice a week.

- ☐ 5. Three or four times a week.
- ☐ 6. Five or more times a week.
- ☐ 7. Daily or more often.

**79.** Which of the following describes your experience with sexual intercourse?

- ☐ 1. Very enjoyable.
- ☐ 2. Mostly pleasant.
- ☐ 3. Occasionally pleasant.
- ☐ 4. Neither pleasant or unpleasant.
- ☐ 5. Mostly unpleasant.
- ☐ 6. Very unpleasant.
- ☐ 7. Not applicable.

**80.** During intercourse have you imagined that your sex partner was someone else?

- ☐ 1. Frequently.
- ☐ 2. Occasionally.
- ☐ 3. Once or twice.
- ☐ 4. Not at all.

**81.** Have any of the following prevented you from freely expressing your sexuality? (You may check more than one.)

- ☐ 1. Fear of pregnancy.
- ☐ 2. Fear of disease.
- ☐ 3. Social disapproval.
- ☐ 4. Guilt feelings.
- ☐ 5. Religious or other moral training.
- ☐ 6. Other (specify).

_____

_____

- ☐ 7. None of the above.

**82.** How would you rate your sex life?

- ☐ 1. Very unsatisfactory.
- ☐ 2. Unsatisfactory.
- ☐ 3. Somewhat unsatisfactory.
- ☐ 4. Somewhat satisfactory.
- ☐ 5. Satisfactory.
- ☐ 6. Very satisfactory.

**83.** What method of contraception do you or your sex partner use?

- ☐ 1. None.
- ☐ 2. Rhythm.
- ☐ 3. Withdrawal.
- ☐ 4. Diaphragm.
- ☐ 5. Foam, jelly, or other chemical means.
- ☐ 6. Condom.
- ☐ 7. Intrauterine loop.
- ☐ 8. Pill.
- ☐ 9. Not applicable.

**84.** How does contraception affect your sex life?

- ☐ 1. Greatly increases satisfaction.
- ☐ 2. Somewhat increases satisfaction.
- ☐ 3. No effect on satisfaction.
- ☐ 4. Somewhat decreases satisfaction.
- ☐ 5. Greatly decreases satisfaction.
- ☐ 6. Not applicable.

**85.** When your spouse makes sexual advances, how do you usually react?

- ☐ 1. Respond in kind.
- ☐ 2. Accept with little or no response.
- ☐ 3. Accept but with some reservation.
- ☐ 4. Accept but with much reservation.
- ☐ 5. Usually avoid them.

**86.** (FEMALES) How often do you reach orgasm in sexual intercourse?

- ☐ 1. Several times on most occasions.

☐ 2. Almost every time.

☐ 3. About three-quarters of the time or more.

☐ 4. About half the time.

☐ 5. About one-fourth of the time.

☐ 6. Almost never or never.

☐ 7. Not applicable.

**87.** (MALES) Do you have difficulty achieving an erection?

☐ 1. Frequently.

☐ 2. Occasionally.

☐ 3. Seldom.

☐ 4. No.

**88.** (FEMALES) Have you ever undergone abortion or deliberate miscarriage?

☐ 1. Yes, more than once.

☐ 2. Yes, once.

☐ 3. No.

**89.** (FEMALES) If you have undergone abortion, how was it obtained?

☐ 1. Legally.

☐ 2. Illegally.

☐ 3. Not applicable.

**90.** Do you have erotic dreams?

☐ 1. Frequently.

☐ 2. Occasionally.

☐ 3. Not sure.

☐ 4. Seldom.

☐ 5. None I can remember.

**91.** Have you voluntarily obtained or seen erotic or pornographic books, movies, magazines, etc.?

☐ 1. Frequently.

☐ 2. A few times.

☐ 3. Once or twice.

☐ 4. No, but I would like to.

☐ 5. Not interested.

☐ 6. Never would.

**92.** What is your response to erotic or pornographic material?

☐ 1. Greatly aroused.

☐ 2. Aroused occasionally.

☐ 3. No reaction.

☐ 4. Mixed arousal and disgust.

☐ 5. Usually disgusted.

☐ 6. Avoid it.

**93.** Since you were thirteen, have you had homosexual or Lesbian sexual experiences?

☐ 1. Whenever I have sexual intercourse.

☐ 2. Frequently.

☐ 3. Several times.

☐ 4. Once or twice.

☐ 5. Once or twice, but didn't enjoy it.

☐ 6. Never, but I've thought about it.

☐ 7. Never, and would not.

**94.** Over the past six months, how often have you masturbated?

☐ 1. Several times a day.

☐ 2. Daily.

☐ 3. Three or four times a week.

☐ 4. Twice a week.

☐ 5. Three or four times a month.

☐ 6. Once or twice a month.

☐ 7. Once or twice.

☐ 8. Not at all.

**95.** Has your sex partner stimulated your genitals orally?

- ☐ 1. Frequently.
- ☐ 2. Several times.
- ☐ 3. Once or twice.
- ☐ 4. Never, but I would like it.
- ☐ 5. Never, and I wouldn't permit it.

96. Have you orally stimulated the genitals of your sex partner?

- ☐ 1. Frequently.
- ☐ 2. Several times.
- ☐ 3. Once or twice.
- ☐ 4. Never, but I've wanted to.
- ☐ 5. Never, and it is unlikely that I ever would.

97. Have you engaged in anal intercourse?

- ☐ 1. Frequently.
- ☐ 2. Several times.
- ☐ 3. Once or twice.
- ☐ 4. Never, but I've wanted to.
- ☐ 5. Never and it's unlikely that I ever would.

98. How often was sex the subject of general family conversation while you were a child?

- ☐ 1. Frequently.
- ☐ 2. Occasionally.
- ☐ 3. Seldom.
- ☐ 4. Never.

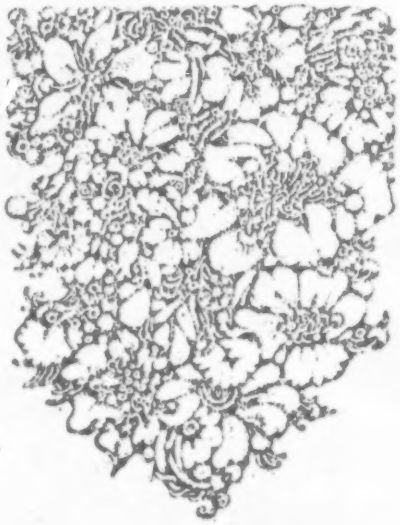
99. Where did you get most of your information about sex when you were a youngster?

- ☐ 1. Friends of the same age.
- ☐ 2. Older friends.
- ☐ 3. Parents.
- ☐ 4. Sex education books.
- ☐ 5. Erotic or pornographic literature.
- ☐ 6. Course in school.
- ☐ 7. Church.
- ☐ 8. Other (please specify).

_____

100. How would you rate your own sexual attitudes as compared to those of the average person?

- ☐ 1. Very liberal.
- ☐ 2. Somewhat liberal.
- ☐ 3. Moderate.
- ☐ 4. Somewhat conservative.
- ☐ 5. Very conservative.



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